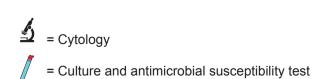
FECAVA Recommendations for Appropriate Antimicrobial Therapy

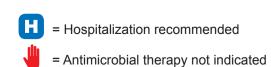


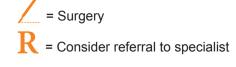


Body system	SKIN				RESPIRATORY Upper Lower				UROGENITAL			ORAL GASTRO-ENTERIC		ABDOMINAL		BLOOD OR		PAEDIC		
	Coat care, thermoregulation, sterilisation of grooming equipment mandatory																			
Common conditions	Surface pyoderma (microbial overgrowth, fold pyoderma, acute moist dermatitis)	Superficial pyoderma (bacterial folliculitis, impetigo)	Deep pyoderma (furunculosis, cellulitis)	Otitis externa	Wound/soft tissue infections and abscesses	Rhinitis	Acute bronchitis (e.g. kennel cough) Chronic Bronchitis	Pneumonia	Pyothorax	Upper urinary tract infection (pyelonephritis)	Lower urinary tract infection	Pyometra	Oral infection (e.g. gingivitis, stomatitis, peri- odontitis)	Gastroenteritis	Anal gland abscessation	Hepatic disease (cholecystitis, cholangitis, cholangiehep- atits)	Peritonitis	Sepsis	Septic arthritis	Osteomyelitis
Cytology and culture	from impression smears, tape strips	(if possible)	following biopsy or by aspiration (not from surface exudate)	of ear swabs obtained after preliminary cleaning not relevant due to topical therapy	of surgical site infections of if	Usually not indicated, limited clinical significance due to presence of commensal flora Samples collected by biopsy may be considered in chronic cases	Usually not indicated, limited clinical significance due to presence of commensal flora	Difficulties with bronchoalveolar lavage include patient stability and getting representative sample Differentiate on clinical/historical basis: life threatening disease vs animals with no symptoms and contact with other animals	on aspirate by thoracocentesis (both aerobic and anaerobic incubation)	of urine (collected by cystocentesis)	most cases (urine collected by cystocentesis)	Usually not indicated (unless rupture, see peritonitis)	Not indicated, limited clinical significance due to presence of commensal flora	Usually not indicated On specific suspicion submit for Salmonella Campylobacter (Speciation required) and toxigenic clostridia	of wound cavity if severe tissue damage &/or fever (peform deep glandular swabbing to avoid contaminants)	of aspirate or biopsy (gall bladder aspirate preferred under GA/sedation)	of aspirate obtained by abdominocentesis (both aerobic & anaerobic incubation)	aseptically taken blood samples taken over a 24-hour period (both aerobic and anaerobic incubation)	of synovial aspirate or biopsy (synovial membrane). Before isolation and sensitivity testing incubate sample in blood culture medium for 24 h at 37° C	Radiography & of bone biopsy
Likely pathogen	Staphylococcus pseudinterme- dius/Malassezia sometimes involved)	Staphylococcus pseudinterme- dius	Staphylococcus pseudinterme- dius	Cocci (mainly Staphylococcus pseudintermedius), rods (mainly Pseudomonas), and/or yeasts (Malassezia)	Variable	Variable often viral +/- second- ary opportunistic infection in cats	Viral Consider chronic causes of Chronic Bronchitis		Variable, including anaerobes Consider <i>Mycoplasma spp</i>	Escherichia coli	Escherichia coli	Escherichia coli	Variable (including anaerobes)	Dietary indiscretion or change most likely. Mainly viruses (or parasites in young animals Faecal sample for parasitology on suspicion)	Variable, including anaerobes E.coli, Enterococcus and Proteus common	Variable for cholangitis/ cholangio-hepati tis <i>E.coli</i> , <i>Enterococcus spp.</i> , <i>Strep. spp.</i> , anaerobes. occ. leptospirosis	Variable	Variable (including anaerobes)	Variable. If surgical (or seccondary to surgery), probable Staph pseudointermedius infection	Variable. If surgical (or seccondary to surgery), probable Staph pseudointermedius infection
Empirical antimicrobial choice		Avoid empirical choice if multiresistant bacteria (e.g. MRSP, MRSA, ESBL) possible Clindamycin or 1st generation cephalosporins or TMPS or amox/dav		Antiseptics often sufficient Topical treatments Utilise Cascade in ongoing cases	dressings are usually sufficient. Systemic therapy based on	With secondary chronic purulent rhinitis consider doxycycline. Antivirals e.g. famcyclovir useful for FHV-1 in cats	In poorly responsive cases >10 days or secondary pneumonia suspect Bordetella bronchiseptica	Doxycycline orally (mild disease). Parenteral fluoroquinolone (severe symptoms)	If cocci use amox-clav, if rods use fluoro- quinolones	TMPS or fluoro- quinolone while pending If signs of sys- temic infection see sepsis	ONLY when inflammation and infection present on cytology i.e. septic neutrophils +/- intracell bacteria Amoxicillin or TMPS while pending	In severe* cases use fluoroquinolones		Self-limiting If signs of systemic infection see sepsis	In severe tissue damage &/or fever use TMPS while pending ampicillin or Amox/clav in cats tx	Amox/clav, ampicillin pending Doxycycline or 1st gen. cephalosporins possibly fluoro- quinolones for enterobacteria	Penicillin G or amoxicillin or ampicillin IV Also fluoroquinolones	Clindamycin,	Clindamycin or 1st. gen. cephalosporins or amoxclav	Clindamycin or 1st gen. cepha- losporins while pending
Remarks on therapy	lotions, spray, gels, creams, etc e.g. chlorohex- idine with ad- equate contact	(e.g. chlorhex-idine) if infection	Always combine with topical therapy (e.g. chlorhexidine shampoo) Treat until clinical signs have completely resolved at follow up consultation	Clean before therapy, & continue for prophylaxis. Reduce swelling & inflammation with glucocorticoids (can be curative) Investigate and resolve underlying causes. Consider systemic therapy with ulceration	usually not recommended with granulating wounds If always take sample after	days, consider systemic antibi- otics Always address primary cause in	If symptoms persist >10 days, consider systemic antibiotics Treat with doxy- cycline or TMPS or amox-clav 3 times daily	Amoxicillin or ampicillin preferably as a constant rate infusion or 3 times daily orally In severe* cases use a fluoroquinolone & penicilin G or clindamycin	Drainage and lavage are essential for clinical resolution Amox-clav 3 times daily	Amox-clav 3 times daily	Amoxicillin 3 times daily	Medical treatment (occasional, not recommended) 4-5 days fluotoquinolones (or TMPS) and e.g. aglepristone	and/or dental treatment If signs of systemic infection (fever, lymphadenopathy) use clindamycin or metronidazole and spiromycin	Some evidence for use of pro- biotics in acute GE-speeds recovery and targets intestinal dysbiosis Diet modification useful	Drainage and lavage Local instillation of antimicrobials Removal if recurrence	H	Correction of primary cause (if possible), copious lavage essential Amoxicilin or ampicilin preferably as a constant rate infusion or 3 times daily	Amoxicillin or ampicillin preferably as a constant rate infusion or 3 times daily Treat underlying trigger aggressively, e.g. resection/drainage/lavage needed of e.g. wound/pyothorax	Copious lavage (aseptic) of joint space with saline or Ringer's lactate Amoxicillin-clav 3 times daily	Look for primary cause Remove implants if possible

This table provides examples and should not be considered comprehensive. Local resistance patterns have to be taken into consideration. Use an antimicrobial with shown bioavailability at target otgan and use as narrow spectrum as possible. Always follow national legislation.







ESBL = Extended spectrum beta-lactamase

MRSA = Methicillin-resistant Staphylococcus aureus

MRSP = Methicillin-resistant Staphylococcus pseudintermedius

TMPS = Trimethoprim-sulfonamide

Severe*= Sign of sepsis